About Your Child

Name ____ Preferred Name ________________
Last First MI

Child's Home Address ____

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Date of Birth __________ Age ___ Male___ Female___ School ____________________________

Sports/ Hobbies/ Interests ____

Is your child concerned about their smile? ____

Dentist ___________________________ Family members seen by us _________________________

Who may we thank for referring you? ____

Parent/ Guardian

Name _______________________________________ Relationship to Child __________________

Address *(if different from child's)* ____

____

Cell Phone ___________________ Home ___________________ Work ___________________

Email _____________________________ Preferred Method of Contact __________________

Parents' Relationship *(please circle):* Single Married Partnered Divorced Separated Widowed

Mother/ Guardian's Name ________________________ Preferred Phone ______________________

Place of Employment ____________________________ Occupation ___________________________

Father/ Guardian's Name ________________________ Preferred Phone ______________________

Place of Employment ____________________________ Occupation ___________________________

Primary Insured Name ___________________________ S.S. # of Insured _____________________

Insurance Company _____________________________ Date of Birth _________________________

Secondary Insured Name _________________________ S.S. # of Insured _____________________

Insurance Company _____________________________ Date of Birth _________________________

______________________________ ______________________________ _______________

Parent/ Guardian Signature Printed Name Date

DENTAL AND MEDICAL HISTORY

Please circle any items that apply to your child.

CONCERNS
Crowding
Spacing
Misaligned teeth
Overbite
Protrusion of teeth
Receded jaw
Prominent jaw
Missing teeth
Irregular teeth (shape, color)
TMJ pain/ disorder

DENTAL HISTORY *(Past or present)*
Injury to teeth/ jaw/ face
Jaw or face pain
Clicking/ popping/ locking of jaw
Clenches jaw/ grinds teeth
Thumb/ finger habit
Chews on object (nails, pens, other)
Tongue thrust
Mouth breathing

Has your child had a previous orthodontic evaluation? ________________________

CURRENT MEDICATIONS *(please list)*:

____

____

____

MEDICAL HISTORY *(Past or present)*
ADD/ ADHD
Allergies
Asthma
Autoimmune disorder
Blood disease
High blood pressure
Bone disease/ arthritis
Diabetes
Delayed growth
Eating disorder
Emotional concerns
Endocrine disorder
Epilepsy/ seizures/ fainting spells
HIV+/ AIDS
Heart disease
Heart murmur
Hepatitis
Hearing impairment
Speech impairment
Tonsils/ adenoids removed

Has your child reached puberty? ___________

ALLERGIES
Latex Nickel Plastic

Medications ____________________________

Other _________________________________

Emergency Contact Name ______________________________ Phone ________________________

Please provide any additional information you feel is important ________________________________

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______________________________ ______________________________ _______________

Parent/ Guardian Signature Printed Name Date